# NFL Player Disability & Neurocognitive Benefit Plan

# Neurocognitive Disability Benefit Application

## Neurocognitive Disability Benefit Application

# INSTRUCTIONS

### Important Reminders

- **Read all explanations and instructions carefully.**

- **Fill out the Neurocognitive Disability Benefit Application ("Application") to apply for neurocognitive disability benefits from the NFL Player Disability & Neurocognitive Benefit Plan ("Disability Plan").**

  If you have any questions about your Application, call the Plan Office at 800-638-3186.

- **Mail the completed Application and documentation to:**

  NFL PLAYER DISABILITY & NEUROCOGNITIVE BENEFIT PLAN
  200 SAINT PAUL ST STE 2420
  BALTIMORE MD 21202

To apply for neurocognitive disability benefits from the Disability Plan, you must complete this Application and return it to the Plan Office with all required information. The Plan Office will tell you if further information is required. Your Application will not be complete until the Plan Office receives this Application with all required information, and receives all documents and additional information that you intend to include.

### Signature and Authorization

Your signature certifies that the information provided is accurate and complete, and authorizes the consideration and use of your medical information to evaluate your Application. In connection with your Application, you may submit, or have submitted on your behalf, individually identifiable health information, including your disability Application, medical records, and physician reports. You also may be referred to Plan-neutral physicians or Medical Advisory Physicians for medical examinations, and these physicians may submit health information to the Disability Plan on your behalf. If you do not appear at any medical examination, your Application will be denied, unless you provide at least 2 business days advance notice of your inability to attend. This rule may be waived if circumstances beyond your control preclude your attendance without advance notice.

**You may be subject to loss of benefits and to other penalties and sanctions under law if you have made any false or misleading statements or omissions.**

### Medical, Hospital, and Other Records

You are strongly encouraged to provide any information you believe will be helpful to the consideration of your Application, such as treatment records relating to any psychiatric/psychological conditions you may have, transcripts from colleges or graduate schools attended, reports from baseline neuropsychological tests, and the like. Such materials may be critical in establishing your eligibility for benefits.

To qualify for the benefit, you must receive a qualifying report from the Disability Plan's doctors. Your past medical records will help the Disability Plan's neuropsychologists and neurologists understand your neurocognitive function. Medical, hospital, and other records must be received by the Plan Office no less than 10 days before the date of your neutral physician exam. Such materials received within 10 days will not be considered by the neutral physician.

## Impairments

On the Application, please identify all symptoms of neurocognitive impairment you are experiencing.

## Release

To receive the neurocognitive disability benefit, you must agree that you will not sue the NFL or any NFL Club in connection with any claim you may have now or in the future in connection with any head and/or brain injury. The release is a part of this Application. Your Application will not be complete, and will not be processed, unless you sign the release. You should read the release carefully and, if you need help understanding it, seek counsel from an attorney.

The release will be enforced if:

- You receive neurocognitive disability benefits.
- You are determined by the Disability Plan to be medically eligible for neurocognitive disability benefits, but you decline to receive them.

The release will be null and void if:

- Your application is denied.
- You do not receive neurocognitive disability benefits because you also qualified for total and permanent disability benefits or line-of-duty benefits under the Disability Plan or the Bert Bell/Pete Rozelle NFL Player Retirement Plan that are more generous than neurocognitive disability benefits.

## Standards

To qualify for neurocognitive disability benefits, you must be determined by the Disability Plan to have a mild or moderate neurocognitive impairment. You will be referred to Disability Plan neutral physicians to help the Plan determine whether you have either of these conditions.

- You have a mild neurocognitive impairment if you have problems with one or more domains of cognitive functioning which reflect acquired brain dysfunction, but these problems are not severe enough to cause marked interference in day-to-day activities.
- You have a moderate neurocognitive impairment if you have problems with one or more domains of cognitive functioning which reflect acquired brain dysfunction resulting in marked interference with everyday life activities, but these problems are not severe enough to prevent you from working.

You will not be eligible for neurocognitive disability benefits if your neurocognitive impairment is caused by substance abuse or a psychiatric condition.

***Mail the completed Application and required documentation to:***

NFL PLAYER DISABILITY & NEUROCOGNITIVE BENEFIT PLAN
200 SAINT PAUL ST STE 2420
BALTIMORE MD 21202

***If you have any questions, please call the Plan Office at 800-638-3186.***

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## Neurocognitive Disability Benefit Application

### Signature and Authorization

I certify that all information and documents provided on or with this Application are, to the best of my knowledge, true, correct, and complete. I also authorize the Disability Plan to use or disclose all individually identifiable health information submitted on my behalf, or created in connection with my Application, to all individuals as needed for Plan purposes.

In submitting this application, I represent and warrant that 1) I am under 55 years of age; 2) I am a vested Participant in the Bert Bell/Pete Rozelle NFL Player Retirement Plan due to Credited Seasons; and 3) I have at least one Credited Season after 1994. I understand that I may be required to undergo a comprehensive evaluation, and I certify that I will be able to attend such evaluation within 30 days from the date this Application is received by the Plan Office. I understand that failure to attend without 2 business days advance notice, and cooperate with such evaluation will result in my Application being denied.

Signature of Player _____ Date Completed _____

### Player Information

Player's Name *(please print)* _____
Last First Middle Initial

Date of Birth _____ Social Security Number _____

Address *(number and street)* _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Mobile Phone _____ E-mail _____

### Medical, Hospital, and Other Records

Have you included additional information in support of your Application for neurocognitive disability benefits?

❍ Yes ❍ No If yes, what is enclosed? _____

Are there other documents that you intend to include that you have not submitted with this Application?

❍ Yes ❍ No If yes, what will you be sending? _____

Note: Applications cannot be processed until all information is received. Please send all supporting information to the Plan Office as soon as possible, or notify the Plan Office if you decide not to send additional information.

— CONTINUED ON NEXT PAGE —

Player's Name *(please print)* _____ Initials _____

## Impairments

Please describe the problems you are experiencing as a result of neurocognitive impairment.
*(Attach an additional sheet if necessary)*

_____

_____

_____

_____

_____

_____

_____

Are you receiving any ongoing treatment for the symptoms described above? If so, please describe below, including physicians and dates of treatment in the last three years. *(Attach an additional sheet if necessary)*

_____

_____

_____

_____

_____

_____

_____

Have you received a diagnosis of any condition relating to your impairment?

❍ Yes ❍ No If yes, what was the diagnosis(ses)? _____

_____

_____

_____

_____

_____

_____

— CONTINUED ON NEXT PAGE —

Player's Name *(please print)* _____ Initials _____

## Release and Covenant Not to Sue

**You must sign the following release for your Application to be processed.**

In consideration for the benefit provided under Article 65 of the Collective Bargaining Agreement between the NFL Management Council and the NFLPA, Player, on his own behalf and on behalf of his personal representatives, heirs, next of kin, executors, administrators, estate, assigns, and/or any person or entity on his behalf, hereby waives and releases and forever discharges the NFL and its Clubs, and their respective past, current, and future affiliates, directors, officers, owners, stockholders, trustees, partners, servants, and employees (excluding persons employed as players by a Club) and all of their respective predecessors, successors, and assigns (collectively, the "NFL Releasees") of and from any and all claims, actions, causes of actions, liabilities, suits, demands, damages, losses, payments, judgments, debts, dues, sums of money, costs and expenses, accounts, in law or equity, contingent or non-contingent, known or unknown, suspected or unsuspected ("Claims") that the Player has, had, may now have, or may have in the future arising out of, relating to, or in connection with any head and/or brain injury sustained during his employment by the Club, including without limitation head and/or brain injury of whatever cause and its damages (whether short-term, long-term, or death) whenever arising, including without limitation neurocognitive deficits of any degree, and Player covenants not to sue the NFL Releasees with respect to any such Claim or pursue any such Claim against the NFL Releasees in any forum. This release, waiver, and covenant not to sue includes without limitation all Claims arising under the tort laws of any state and extends to all damages (including without limitation short-term and/or long-term effects of such injury and death) whenever arising, including without limitation after execution of this release, waiver, and covenant not to sue. Player further acknowledges that he has read and understands section 1542 of the California Civil Code, which reads as follows:

> A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if known by him must have materially affected his settlement with the debtor.

Player expressly waives and relinquishes all rights and benefits under that section and any law of any jurisdiction of similar effect with respect to the release of any unknown or unsuspected claims released hereunder that Player may have against the NFL Releasees. This release, waiver, and covenant not to sue shall have no effect upon any right that Player may have to insurance or other benefits available under any Collective Bargaining Agreement between the NFL Management Council and the NFLPA, or under the workers' compensation laws, and Player acknowledges and agrees that such rights, if any, are his sole and exclusive remedies for any Claims.

Player acknowledges and agrees that the provision of the benefit under Article 65 shall not be construed as an admission or concession by the NFL Releasees or any of them that NFL football caused or causes, in whole or in part, the medical conditions covered by the benefit, or as an admission of liability or wrongdoing by the NFL Releasees or any of them, and the NFL Releasees expressly deny any such admission, concession, liability, or wrongdoing.

Dated this _____ day of _____, 20_____.

Signature of Player _____

Printed Name of Player _____

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# NFL Player Disability & Neurocognitive Benefit Plan

## Disability Benefit Player Consent Form

### Signature and Authorization

You are applying for disability benefits under the NFL Player Disability & Neurocognitive Benefit Plan ("Plan"). This form contains important information. Please read the form, sign it, and return it with your application for disability benefits. This form is a required part of the application, and must be completed before your application will be processed.

I, _____ *(print name)*, have read and understood the information in this Disability Benefit Player Consent Form.

Signature of Player _____ Date Completed _____

**In submitting my application for disability benefits, I understand that:**

1. I may be required to attend a physical examination with one or more physicians or other health professionals, and that failure to attend may cause my application to be denied.

2. There will be no doctor-patient relationship between me and the physicians or other health professionals who examine me.

3. The physicians or other health professionals who examine me will provide reports on my condition to the Plan, which I may obtain by written request to the Plan Office.

4. The physicians or other health professionals who examine me will not provide a copy of the medical reports to me directly.

5. Neither I nor my representatives (attorneys, treating physicians, etc.) are allowed to contact the physicians or other health professionals arranged by the Plan, such as to discuss their examination of me or to request copies of reports.

6. The physicians or other health professionals who examine me are required to comply with ethical or legal obligations, for example if they determine that I am a danger to myself or to others.

7. By signing this form, I consent to the above points and will comply with the Plan's procedures in connection with my claim for disability benefits.

8. The examination will not be videotaped or otherwise recorded.